STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/12/13 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Lowell Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was built as a two story building over a partial basement with a two story addition offset and connected to the original structure by a stairway prior to March 1, 2003. The construction was determined to be of Type II (111) construction and was fully sprinklered.	K010000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility has a fire alarm system with hard wired smoke detection in the corridors and common areas. Resident rooms are provided with battery powered smoke detectors. The facility has the capacity for 90 and had a census of 74 at the time of this survey. All areas accessible to residents are sprinklered. Areas providing facility services are sprinklered with the exception noted at K-56. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/21/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K010017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure an open use area in 1 of 5 smoke compartments was separated from the corridor by smoke resistant walls, extending from the floor to the roof above, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by	K010017	**K017** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An electrically supervised automatic smoke detection system was added in the Business Office. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All offices were assessed for the need of a smoke detection system. Electrically supervised automatic smoke detections systems were added to all offices that were needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/11/2013

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	quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects visitors, staff and 38 residents on the first floor. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 at 11:50 a.m., the business office was separated from the exit corridor by two sliding glass window panes which gapped a quarter of an inch when closed. The administrator acknowledged at the time of observation, the office was not always occupied and closed at the end of the business day. There was nothing to prevent the passage of smoke from the business office into the adjacent corridor in the event of fire. Additionally, the area was not protected by an electrically supervised automatic smoke detection system or located to permit direct supervision by the facility staff from a nurse's station or similar space when unoccupied.		The Maintenance Director will be re-educated by the E.D. regarding the need for automatic smoke detection systems on 3/26/13. The Maintenance Director will monitor all rooms needing a smoke detection system during his monthly PM rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all offices in need are equipped with an automatic smoke detection system. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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	3.1-19(b)			

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K010021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure smoke barrier doors on 2 of 4 levels were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 72 residents on the first and 2 East floors. Findings include: Based on observation with the maintenance director and administrator between 12:15 p.m. and 2:00 p.m., one door in each of the two smoke barrier double door sets on the first and 2 East floors failed to close when tested twice manually to ensure their proper operation. A latch at the top of each door stuck and prevented the doors from closing into	K010021	**K021** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The two fire doors now latch into their door frames when released manually or by the fire alarm system. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All fire doors in the facility were tested to ensure they all latched into their frames when released manually or by the fire system. All other fire doors latched when released. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	their door frames. The doors failed to close again when the fire alarm system was activated. The maintenance director acknowledged at the time of observations, the latches were malfunctioning. 3.1-19(b)		The Maintenance Director will be re-educated by E.D. regarding the need for all fire doors to latch into their door frames on 3/26/13. The Maintenance Director will monitor all fire doors during the monthly fire drills to ensure they all release and latch into their door frames. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all fire doors latch into their door frames when released. The E.D. will then sign off on the Maintenance Director's monthly PM/fire drill schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas, such as a boiler/mechanical room, was separated from other spaces by a smoke resistant partition. This practice could affect visitors, staff and an 38 residents on the first floor. Findings include: Based on observation with the maintenance director and administrator on 3/12/13 at 12:25 p.m., a ten foot by two inch opening existed above the lay in ceiling in the boiler/mechanical room between the first floor boiler/mechanical room and the adjacent resident restroom. The maintenance director acknowledged at the time of observation, no seal was in place between the concrete block wall and the corrugated metal deck separating the boiler/mechanical room from the adjacent	K010029	**K029** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The opening in the boiler/mechanical room on 1 st floor was sealed to ensure it was separated from other spaces by a smoke resistant partition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All hazardous areas were inspected to ensure they were all separated from other spaces by a smoke resistant partition. Any concerns found were addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	space. 3.1-19(b)		re-educated by E.D. regarding the need for all hazardous areas to be separated from other spaces by a smoke resistant partition on 3/26/13. The Maintenance Director will monitor all hazardous areas during the monthly PM to ensure they are all separated from other spaces by a smoke resistant partition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all hazardous are separated from other spaces by a smoke resistant partition. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure a locked exit door on 1 of 4 levels unlocked upon activation of the fire alarm system. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to be carried by staff at all times, or other such reliable means available to the staff at all times. This deficient practice affects staff, visitors, and 34 residents on the 2 East second floor. Findings include: Based on observation of the north exit from the second floor with the maintenance director and administrator on 03/12/13 at 2:10 p.m., the north exit door from the 2 East second floor was equipped with a magnetic door lock designed to release upon activation of the fire alarm, a power outage and a code entered into the keypad adjacent to the exit door. The maintenance director entered the required code and the lock disengaged, however, when the fire alarm was activated the door did not unlock.	K010038	**K038** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The locking mechanism that malfunctioned on the north exit door was replaced. The door currently unlocks when the fire alarm is activated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All exit doors were tested to ensure they all unlocked when the fire alarm was activated. All other exit doors were functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be re-educated by E.D. regarding the need for all exit doors to unlock upon activation of the fire alarm on 3/26/13. The Maintenance Director will monitor all exit doors during the monthly fire drills to ensure they all unlock upon activation of the fire alarm. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what**	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	The administrator and maintenance director agreed at the time of observations, the locking mechanism was malfunctioning. 3.1-19(b)		**quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all exit unlock upon activation of the fire alarm. The E.D. will then sign off on the Maintenance Director's monthly PM/fire drill schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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	155448	A. BUILDING 01 B. WING	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K010046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 2 of 67 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 74 residents on the first and 2 East floors. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 between 1:00 p.m. and 3:00 p.m., both bulbs in the battery powered emergency lighting in the corridor near rooms 118 and 318 failed to illuminate when tested twice. The maintenance director acknowledged the failure of the lighting fixtures at the time of the observations. 3.1-19 (b)	K010046	**K046** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The two emergency lighting fixtures that did not operate were replaced. Both fixtures are currently functioning properly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All emergency lighting in the facility was tested for proper function. All other emergency lights were functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be re-educated by E.D. regarding the need for all emergency lighting to function properly on 3/26/13. The Maintenance Director will monitor all emergency lighting during the monthly PM to ensure they all function properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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			To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all emergency lights function properly. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a fire plan which included the identification the types of fire extinguishers available, the use and location of the ionized water fire extinguisher and complete information regarding activation of the overhead kitchen hood extinguishing system in the written fire plan for the protection of 75 of 75 residents. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: 1. Use of alarms. 2. Transmission of alarms to fire department. 3. response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the Fire Prevention and General Fire Action with the	K010048	**K048** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The fire plan was updated to identify the types of fire extinguishers available, the use and location of the ionized water fire extinguisher, and complete information regarding activation of the overhead kitchen hood extinguishing system. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All copies of the fire plan were updated and dispersed throughout the facility so the information is readily available. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced by the S.D.C. on the types of fire extinguishers available, the use and location of the ionized water fire extinguisher, an complete information regarding activation of the overhead kitchen hood extinguishing system. The Maintenance Director will be re-educated by the E.D. regarding	04/11/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 B. WING	03/12/2013

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	maintenance director and administrator on 03/12/13 at 3:10 p.m., the policy and procedure was incomplete. There was no identification of the ABC and ionized water fire extinguisher locations and their use. In addition, the Fire Prevention policy did not identify the kitchen overhead extinguishing system as an automatically activated system. The policy provided information as to the location of the pull ring which should be used in the event the automatic activation did not occur. The plan also referred to "Smoke detectors are located throughout the building in the ceiling. This detection system will activate whenever smoke is present. Upon activation, the smoke doors, located in the corridors, will close automatically." The administrator acknowledged at the time of record review, the fire plan did not include battery powered smoke detectors and no mention was made of the fact these devices would not activate the fire alarm and door closing. 3.1-19(b)		the need for the fire plan to identify the types of fire extinguishers available, the use and location of the ionized water fire extinguisher, an complete information regarding activation of the overhead kitchen hood extinguishing system on 3/26/13. The Maintenance Director will monitor all disaster manuals during the monthly PM to ensure they include the correct information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all disaster manuals include a fire plan that identifies the types of fire extinguishers available, the use and location of the ionized water fire extinguisher, an complete information regarding activation of the overhead kitchen hood extinguishing system.. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 B. WING	03/12/2013

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K010056 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 2 stories in a building of Type II (111) construction. LSC 19.1.6.2 requires facilities of Type II (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 38 residents on the first floor. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 at 11:55 a.m., sprinkler protection was not provided for the closet in the admissions office. The administrator acknowledged at the time of observation, the closet was not provided with a sprinkler. He said it was not	K010056	**K056** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Sprinkler coverage was added in the admissions office closet.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All rooms/closets in the facility were checked to ensure there was complete sprinkler coverage provided. No other spaces were found without sprinkler coverage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be re-educated by the E.D. regarding	04/11/2013

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	installed when the room was renovated and provided documentation for installation of a sprinkler. No date was scheduled. 3.1-19(b) 3.1-19(ff)		the need for complete sprinkler coverage in the facility on 3/26/13. The Maintenance Director will monitor all new additions to the facility during his PM rounds to ensure there is complete sprinkler coverage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure there is complete sprinkler coverage in the facility. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 27 portable fire extinguishers were installed on a hanger, bracket, mounted in a cabinet or set on a shelf. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.6 requires extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. NFPA 10, 1-6.7 requires extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. This deficient practice could affect visitors, staff and 38 resident on the first floor. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 between 12:15 p.m. and 1:00 p.m., an ABC fire extinguisher sat on the floor at the north first floor nurses' station and and an ionized water extinguisher sat on the floor in the assisted dining room. The maintenance director said at the time of observation, the ABC extinguisher was kept ready for use by construction contractors when they were at work. No	K010064	**K064** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The ABC extinguisher was removed from the nurses' station as there are other extinguishers properly mounted in that area. The ionized water extinguisher was mounted on the wall in the assisted dining room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All extinguishers in the facility were inspected to ensure they were properly mounted on the walls. All other extinguishers were mounted properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be re-educated by the E.D. regarding the need for all extinguishers to be mounted properly on the wall on 3/26/13. The Maintenance Director will monitor all fire extinguishers during the monthly PM to ensure they are all mounted properly on the walls.	04/11/2013

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	contractor was on site at the time of the survey. The maintenance director said he did not know why the ionized water extinguisher was on the floor in the assisted dining room. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all extinguishers are mounted properly on the walls. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to enforce facility smoking regulations and ensure smoking was limited to 1 of 1 designated smoking areas. This deficient practice affects staff, visitors and 10 or more residents who might use the elevator in the space just inside the north exit. Findings include: Based on observation with the administrator and maintenance director on 03/12/13 at 12:50 p.m., the area outside	K010066	K066 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The area outside of the north exit was cleaned up. A "no smoking" sign was placed in this area to remind staff it is not a designated smoking area. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The exterior of the building was	04/11/2013

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	the north exit from the first floor near the elevator led to the paved parking lot. The perimeter adjacent to the building, exit discharge and generator was composed of dirt and grass, covered with a thick layer of dead leaves with an accumulated carpeting of cigarette butts. Some paper trash and a used latex glove were lying among the debris. The administrator confirmed at the time of observation, this was not a designated smoking area. A review of the employee No Smoking Policy provided by the administrator on 03/12/13 at 3:15 p.m. noted, "Under no circumstances are employees to use their break period to smoke or eat in any area of the building other than the one designated by management for that purpose." The designated smoking area was located at picnic tables outside the south exit. The administrator confirmed at the time of record review, the area noted outside the south exit was the only designated smoking area for visitors, residents, and staff. 3.1-19(b)		inspected to ensure no other unauthorized smoking areas were being used to smoke in. No other areas were noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be re-educated by the S.D.C. regarding the designated smoking areas for employees on 3/26/13. The Maintenance Director will inspect the exterior of the facility during his daily rounds and monthly PM and document the areas of free of debris and no unauthorized smoking is occurring. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all unauthorized smoking areas are free from smoking debris and no unauthorized smoking is occurring. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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	155448	A. BUILDING 01 B. WING	03/12/2013

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K010130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 40 of 40 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect visitors, staff and 75 residents. Findings include: Based on review of the "Weekly Smoke Detector Checks" documentation with the maintenance director and administrator on 03/12/13 at 3:40 p.m., an itemized listing of battery operated smoke detector testing for each resident sleeping room location was not done. A check of battery operated smoke detectors was noted for each floor rather than the individual detectors. The maintenance director acknowledged at the time of record review, there was no evidence based on the record provided where each smoke detector was located and the performance of each detector tested on the record provided.	K010130	**K130** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An itemized listing of battery operated smoke detector testing was created. All of the individual smoke detectors will be tested and documented on individually monthly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All battery operated smoke detectors were tested and documented on individually to ensure they were all functioning properly. All smoke detectors were functioning properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will be re-educated by the E.D. regarding the need for itemized listing of battery operated smoke detector testing on 3/26/13. The Maintenance Director will monitor all battery operated smoke detectors during the monthly PM and document they were individually tested to ensure proper function.	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	3.1-19(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure all battery operated smoke detectors are itemized and tested. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage and transfer rooms was arranged to allow oxygen transfer in the room with the door closed to maintain the separation. This deficient practice affects visitors, staff and 34 residents on the 2 East second floor. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 at 1:50 p.m., the oxygen transfer room was identified by the administrator and signs on the door. The room was filled to capacity with liquid oxygen tanks and oxygen concentrators with just a two inch space between the liquid oxygen	K010143	**K143** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Everything except the liquid oxygen was removed from the oxygen room. There is now enough room for proper transferring of oxygen. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** There are no other oxygen transfer rooms in the facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The nursing staff/Maintenance Director will be re-educated by the	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	tanks and the door when closed. The administrator acknowledged at the time of observation, it was a physical impossibility for staff to enter and close the door to fill portable oxygen tanks to separate the transfer activity from the resident use corridor. 3.1-19(b)		S.D.C. regarding the need for adequate space and the need to close the door when transferring oxygen on 3/26/13. The Maintenance Director will monitor the oxygen room weekly to ensure there is adequate room to properly transfer oxygen. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure there is adequate room to transfer oxygen. The D.N.S./designee will observe an oxygen transfer daily for 3 weeks to ensure proper transfer. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	

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	155448	A. BUILDING 01 B. WING	03/12/2013

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K010147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords or multitap adapters were not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 75 residents on the first and second floors. Findings include: Based on observation with the maintenance director and administrator on 03/12/13 between 11:50 a.m. and 3:00 p.m., extension cords or multitap outlet adapters were used to provide power to equipment in the following areas: a. Business office, a power strip for a microwave and refrigerator; b. North nurses station, a surge protector plugged into a multitap adapter; c. Room 121, extension cord to miscellaneous appliances; d. Room 313, surge protector extension cord to power the medical grade mattress; e. Second floor nurses station, a multitap	K010147	**K147** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The power strip in the Business Office was removed. The multitap adapters at the nurses' stations were removed. The extension cord in room 121 was removed. The medical grade mattress was plugged into the wall outlet. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All offices, rooms, and common areas were inspected to ensure there were not any multitap adapters, extension cords, or misuse of surge protectors. Any concerns identified were corrected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Nursing Staff/Maintenance Director will be re-educated by the S.D.C. regarding the proper use of surge protectors and the prohibited use of extension cords/multitap adapters on 3/26/13. The Maintenance Director will monitor all offices, rooms, common areas	04/11/2013

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	155448	A. BUILDING 01 B. WING	03/12/2013

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	adapter. The maintenance director and administrator were removing some of this equipment at the time of observations, but the administrator acknowledged there was a problem with staff and others installing these electrical extensions without prior approval. 3.1-19(b)		during the monthly PM to ensure flexible cords or multitap adapters are not used as a substitute for fixed wiring. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the E.D./designee will be responsible for initially rounding with the Maintenance Director to ensure flexible cords or multitap adapters are not used as a substitute for fixed wiring. The E.D. will then sign off on the Maintenance Director's monthly PM schedule to ensure all monitoring is complete. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/11/13	